California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

Volume 89 NOVEMBER 1958 Number 5

The Use of Ataractic Agents

Some Psychiatric Implications

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• **Physicians should understand the psychic as well as the chemical effects of ataractic drugs, especially since they are prescribed chiefly for illnesses of emotional origin. The patient may feel that he is "being put off with a pill;" on the other hand, both patient and physician may be encouraged (and thus able to work better together) because the prescription of a drug represents "doing something" about the disorder.**

This ability to "do something" may tempt the physician to resort too readily to relieve normal and even healthful tensions of living.

If the drug has pronounced physical effects (especially side effects), the patient may resent the prescription as an aggression; this danger is great if his emotional problem stems from oral and nutritional conflicts of childhood.

ONE OF EVERY THREE prescriptions filled in the United States, according to a recent estimate, is for an ataractic drug. The prescribing physician is well supplied—not to say deluged—with information on the chemical nature of these drugs and on the emotional changes produced by the chemical action of them. The potency of such agents, however, is not limited to the chemical effect; other, more obscure effects are found in the patient's emotional reaction to the very fact of receiving orally a tranquilizing drug. In certain circumstances these latter effects are even more powerful than the chemical action, and these too the physician must understand more than superficially if therapy is to do more good than harm.

That the administration of medicine in itself affects the patient has been widely accepted by the medical profession for many centuries. The empiric use of placebos attests this knowledge, and recent studies have attempted to evaluate the placebo effect more scientifically.[2,15] Another element is the personal administration of the drug by the physician,[3] a time-honored tradition whose importance was frequently stressed by Osler. The complex and intense physician-patient relationship is recognized as significantly coloring the patient's response.

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Submitted May 9, 1958.

Little can be said in a general way about placebo response or the physician-patient relationship that would be surprising to the practicing physician, who deals with these two factors many times every day. However, the opportunity afforded to the psychiatrist, who works with patients on a deeper level of psychic function, has contributed other information of value about emotional reaction to the use of oral ataractic agents.

SIGNIFICANCE OF THE PHYSICIAN'S PRESCRIPTION

Modern psychiatry accepts as a basic tenet the loneliness and social alienation of the emotionally ill person. Sullivan[12] wrote, "—a person with cus-

tomarily low self-esteem has some form or degree of social isolation—that is, some degree of limitations or stipulations on his contact with others." Contact with a respected physician may be a valued exception in a life which has seemed to become, under the cloud of emotional difficulty, an otherwise empty one. The acts of this physician—particularly those which may symbolize his professional attention and power—will come to have unexpected meanings to an isolated, deprived patient. Baker and Thorpe,[2] for example, suggested that the administration of a sweet-tasting placebo comes to represent the interest of a benevolent medical profession. Allen and Mackinnon[1] expanded on this theme: "It is a well-known fact that mentally ill patients will often respond favorably to increased attention and interest in them by those who are treating them." They recalled a legend about the famous French neurologist Charcot, who apparently produced clinical improvement in an emotionally ill patient merely by wiping the patient's nose with his own handkerchief. One of the active factors, they thought, is "the dependent gratification coming from the special attention given to the patient."

The author was made intensely aware of this influence during the process of an experimental study.[6] Patient enthusiasm for participation in the purely experimental work was explained in terms of drive for contact, through the experiment, with the medical profession.

The positive aspect of this interpersonal influence has been emphasized in the preceding paragraphs. There is also a negative side to the picture, illustrated by the following case report:

An 18-year-old college girl was complaining to her psychiatrist of her difficulty in studying for examinations. The patient's problems with regard to her study habits had been the subject of therapeutic investigation for several months already without much clinical improvement in this symptom. The psychiatrist, knowing that anxiety was one of the important elements involved in the symptom formation, decided upon the prescription of an ataractic agent for temporary relief of this anxiety during the critical examination period. Within moments of his proposing this prescription to his patient, he became acutely aware, through the patient's reaction, that he had made some sort of tactical error. After urging the patient to verbalize her reaction, the psychiatrist learned that he had communicated, by implication, a message quite different than that which he had intended. First, the patient had felt rejected. She had been "given a pill rather than understanding." She had been reminded of her mother's habit of popping an aspirin into her mouth when she complained, as a child, of feeling "badly," thereby effectively shutting off the patient's complaints for the time being and releasing the mother from any further responsibility for doing something about those factors which were causing her daughter's unhappiness. The psychiatrist also learned that the patient had interpreted his decision to prescribe the ataractic agent as evidence of his lack of faith in her personal interest in getting her problems worked out and as evidence of a deficiency of confidence in her ability to work them out. She also felt that the prescription implied a lack of respect for the important relationship between the psychiatrist and herself.

DYNAMIC IMPLICATIONS OF THE ATARACTIC AGENT

Another important aspect of the use of tranquilizers is that they are in the "miracle drug" category; their beneficial effect is novel, often rapid and definite. Moreover, they act in a group of disturbances which the physician has found most frustrating and discouraging—the psychosomatic diseases. By giving him a new hand-hold on emotional illness, tranquilizers have cheered the physician as well; he now feels that he can make a more personal investment in the welfare of his emotionally ill patient, take a more personal role in the struggle for relief.

A previous example of this effect of a drug was pointed out by Whitehorn and Betz[14] in the case of insulin therapy for psychosis, where the physician's feeling of being able to "do something" was crucial, these investigators believed, in the recovery of a statistically important number of patients. They observed, too, that the use of insulin affected the behavior of otherwise less therapeutically successful physicians, rendering them more like physicians who were otherwise more successful. The less successful physician seemed better able, when he used insulin, to enter into active personal transaction with his schizophrenic patient. The same increased confidence and enthusiasm may be expected in the practicing physician who approaches the emotional ills of his office or clinic patients with the added weapon of tranquilizers.

Patients and public also are aware of the existence of these drugs, and their attitude toward psychosomatic disease may be similarly altered, as in the case of a 30-year-old professional man who had severe psychoneurotic illness, manifested by phobias, anxiety, hypochondriasis and intermittent depression for 15 years before seeking medical relief of his symptoms. "I felt that the whole thing was hopeless, no one could help me," he explained. However, with the appearance of the many favorable reports on the tranquilizers, the patient began to feel more hopeful and made an active effort to obtain help for his problems. "It really didn't change anything for me but I thought that if a doctor tried to help me and things didn't go so well for a while, he could always give me some relief with one of those new

medicines. . . . I was a lot more optimistic about my chances of getting something done for my sickness."

DANGERS OF ATARACTIC THERAPY

Despite this optimism, merely doing something to relieve symptoms may be dangerous if it satisfies the physician that he has done enough. As Grinker commented, in an interview,[8] "The physician's obligation in treating the sick without harming them involves not only the use of symptomatic remedies but an earnest search for primary causes and for rational measures to prevent or eradicate them. . . . We are doing a disservice to mankind when we as physicians lend ourselves to the prescribing of tranquilizers for the suppression of anxiety from the problems of child rearing, from the frustrations of the housewife's daily life, from the excitement over the canasta table. Frustration anxiety is necessary for learning, growth, and creativity."

In the same interview, Braceland[8] warned about the use of tranquilizers in the medical management of adolescent tensions. "I think a family doctor is smart to refuse to give tranquilizers in such cases. . . . The job is . . . not to quiet the symptoms and let the process go on underneath a tranquilizing drug." Meduna[8] agreed: "Adolescence is the age when you have to learn to be civilized—in other words, to be frustrated. . . . None of these things can be learned without suffering." Along the same line, Bourne[5] pointed out, "When the doctor offers and the patient accepts a drug for an emotional ailment, there may be a tacit agreement to avoid some disagreeable problem"—i.e., the physician's inability to understand the neurosis, the patient's unwillingness to have it explored.

Sarwer-Foner[10] has reported untoward psychologic results of the use of reserpine and chlorpromazine in the treatment of patients hospitalized because of neuroses. Several of these untoward reactions assumed psychotic proportions: (a) One group of patients consisted of men with unacceptable feminine identifications and passivity strivings and doubts about their unacceptable impulses, who "resorted to social, sexual, physical and/or intellectual activity as 'proof' of their manhood." The medication had the adverse effect for these men of "rendering a high level of muscular activity impossible. . . . Chemical interference with long-stabilized modes of expressions was produced. . . . Fear, anxiety, projective as well as autistic thinking, with dissociation of thought process, body image changes, and increased depression were produced." (b) A second group of patients were adversely affected by the interpretations they placed on the purely physical side-effects of the medication. Some regarded these effects as a "changing, or impairing, of their bodies;" others, as the fear of "loss of control over their impulses and their bodies." Symptoms "of depersonalization, marked anxiety, a feeling of strangeness as to their own bodies, paranoid distortions, or increased depression resulted." (c) "Depressed patients became more depressed and anxious." The effects of the drugs "reduced their already limited ability for interpersonal relations and, above all, for expressing aggression. This increased feelings of helplessness, worthlessness, and self-hatred." (d) "A significant number of patients . . . interpreted the effects of the drugs as an assault. . . . The marked and subjectively felt physiological effects of these powerful agents . . . resulted in immediate suspicion, and in the patient distorting the physician's motives for reducing him to this state."

Another danger in the ataractic drug lies in the use to which it may be put after it passes out of the physician's control. The physician may place the responsibility for administration of the drug in the hands of the patient himself, or he may designate the spouse as the dispenser of the drug. The doctor may thus find himself between the Scylla of the danger of patient-administered overdose and the Charybdis of introducing undesirable complications into an already difficult marital relationship. The latter problem arose in the case of a 30-year-old housewife. Because of the prominence of the patient's depression and a history of previous suicide attempts, the physician decided to place the responsibility for the dispensing of the medicine in the hands of the husband. The husband reacted to this responsibility by exaggerating it to a caricature. He locked the medicine in a strongbox and then locked the strongbox in the trunk of his car. It developed, in subsequent psychiatric treatment, that the pattern of interrelationship exemplified in this management of the medicine—the patient's passivity and the husband's combined hostility and withholding tendencies—was one of the basic disorders in this sick marriage. The physician, by making the husband responsible for the medication had unwittingly contributed to the perpetuation of the very illness his prescription was designed to ameliorate.

PSYCHOLOGICAL EFFECTS OF ORAL ADMINISTRATION

One of the few unfortunate consequences of the success of classic Freudian psychology has been the emphasis placed on the sexual aspects of human life. An even more fundamental aspect than sex has to do with the intake of nutrients. Evidence of this primacy comes from many sources—e.g., physiology, psychology, anthropology. Weakland wrote,[13] "Orality, in its broader sense, lately has been receiving increasing psychological attention, and its

importance and pervasiveness in human thought and action are becoming more and more apparent." Weakland was able to demonstrate an undercurrent of concepts related to nutrient intake ("orality") throughout the "sexual" material he investigated. ". . . anthropological data . . . show . . . heterosexual activity being conceived of, quite clearly and consistently, in oral terms."

From this standpoint, the physician as a dispenser of comforting and healing medicines takes on the aspect of a good mother, feeding and supporting the patient-child; the oral medication easily becomes the symbol for the nutrient substance. Levine[9] commented, "Some physicians . . . know in a rather vague way that the giving of medicine to a patient has also a psychologic effect. . . . The psychologic effect is based in part on the fact that in many instances medicine is regarded as a gift from a friendly parent figure, as a sign of affection. In the deepest psychologic layer, the effect is in part based on the fact that medicine has linked with it some of the emotional qualities connected with mother's milk, that it produces some of the feelings of warmth and protection and security that are associated with being fed by a mother."

To the extent that this patient's identification of physician with parent and of medication with nutrient provides security and strength to the patient, it is valuable to treatment. It is axiomatic, however, that the patient who seeks assistance with emotional problems has suffered the misfortune of disturbed relations with his parents at some time during childhood. With the emotionally disturbed patient, the doctor finds himself becoming involved, in a very important way, in the old battles the patient has never stopped fighting inside himself with his parents of long ago. The prescription of oral medicine then becomes, in part, an invitation to the patient to work out some of these internalized child-parent conflicts with the physician as a participant and specifically in the parent role. Many physicians knowingly offer this invitation, confident of their abilities to aid the patient in this specific manner. Other physicians would choose to avoid this involvement. In either case, they need to understand what they are getting into.

Psychoanalytic studies have made other contributions that are informative in this consideration of oral medication. The analytic concepts of "bad mother," "oral invasion," "oral-digestive aggression," "penetration," and "loss of self" are all pertinent to this consideration. When physical or psychic symptoms are related to these concepts the physician's attempts to help the situation will, in part, intensify the very oral-dependency conflicts that originated the disorder. Referring to peptic ulcer patients in this regard, Garma[7] wrote of self-punishing parts of the patient's personality. In this self-afflictive nature is found the danger of the patient's misinterpretation of the doctor's treatment. This part of the personality constitutes an antagonist against which both the patient and the doctor need warn themselves.

Reporting clinical material relating to the same general psychologic areas, Sterba[11] quoted from an address presented by Anna Freud, "In certain persons there exists the misconception and fear that to love anyone means to surrender to the object to an extent which would make them lose their own identity. . . . They would thus be 'invaded' by the love object" (parent or parent-substitute). Sterba added, "the character traits which we have described (negativism, resistiveness, stubbornness, withdrawal, isolation, aggression) seem to serve as a defense against masochistic surrender on an oral-passive level with the consecutive danger of invasion and loss of self." To the extent that these psychologic trends are operative in each patient a tendency will be found on the patient's part toward resistive, uncooperative, or regressive behavior when oral medication is prescribed.

One final consideration in this matter of oral medication has an indirect relationship to a maneuver learned by most physicians early in internship. The young intern soon discovers the trick of popping a thermometer into the mouth of a garrulous patient so that he can more accurately determine the blood pressure level or auscultate the chest. The physician's prescription of oral medication may have a symbolic value similar to that real value of the thermometer. A specifically oral prescription may carry with it the unspoken injunction to a patient to keep quiet about his problems. This possibility raises issues even more complex than appear on the surface. Bateson, *et al.*,[4] introduced the concept of the "double bind" in an article examining the causes of severe emotional disease reactions. "Double bind" characterizes situations in which (1) "the individual is involved in an intense relationship," (2) "two orders of messages (communications) are being expressed to the individual and one of these denies the other, (3) "the individual is unable to comment on the messages being expressed to correct his discrimination of what order of message to respond to." An individual is faced, in an important relationship—perhaps as a patient—with a pair of contradictory communications and is forbidden in various ways to comment on the contradiction presented to him.

The "double bind" is discussed as an important etiologic factor in schizophrenic reactions. It is also presented as having a more general importance. "When a person is caught in a double bind situation, he will respond defensively in a manner simi-

lar to the schizophrenic." In double bind situations "the human being (becomes) like any self-correcting system which has lost its governor; it spirals into never-ending, but always systematic, distortions."

In the physician-patient relationship developed when an oral medication is prescribed, there may be the elements of such a "double bind" situation. The patient is admonished that he needs to speak of his problems, tell the doctor what is bothering him, etc. On the other hand, if he has the misfortune to react to the oral prescription as did the young woman patient previously mentioned who had been "shut up with an aspirin," he finds himself dealing with a conflict in being verbally encouraged to speak but interpreting an unspoken communication to keep his mouth shut. This latter message will also prevent him from protesting about the intolerable contradiction into which he has been put. The development of psychosomatic symptoms may be the patient's response to this predicament. Of course, not every patient given an oral ataractic agent will find himself in this "bind." There will, however, be enough such situations in the offing to warrant the physician's awareness of the possibilities.

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